Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201915482M
Compliance #: HL201917647C

Date Concluded: December 13, 2024

Name, Address, and County of Licensee Investigated:
Burnsville Carefree Living
600 East Nicollet Boulevard
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation:
The alleged perpetrator (AP) emotionally abused the resident when the AP became irritated, yelled at the resident, and placed his finger in his anus and squirted water in it to clean the resident during shower care after the resident had bowel incontinence.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse inconclusive. The AP stated he provided routine shower assistance for the resident which included cleansing around the resident's anal area to remove dried stool. However, the AP denied placing his finger in the resident's anus or yelling at the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the care coordinator, case managers and the resident's medical provider. The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, and related facility policy and

procedures. Also, the investigator interviewed other residents in the facility regarding the care they receive and how facility staff respond to their needs and provide personal care.

The resident resided in an assisted living facility with a diagnosis of schizoaffective disorder. The resident's service plan included assistance with showering, specifically set up supplies and supervision that included helping bathe the resident's backside due to unsteadiness. Assistance with meals, medication administration and diabetes management were also part of the resident's service plan.

A concern arose that the AP put his finger in the resident's anus while giving a shower while squirting water in it during a shower three months prior.

During interview, a case manager, who worked with the resident, stated the resident mentioned multiple times the AP gave him a shower, which was a common task. However, one time the AP had made him feel uncomfortable when the AP had stuck his finger in his anus and yelled at him. The case manager stated he brought the concern forward to the nurse manager, who after she investigated the incident, said she had learned the resident needed more extensive cleaning on that occasion. The case manager stated the resident has moments of paranoia and occasionally misinterpret another person's actions however the case manager asked the AP no longer provide cares for the resident.

During interview, a second case manager stated the resident described the same concern to her and that it happened about three months prior to when he told her.

During an interview, a nurse stated she interviewed the resident regarding the allegation after she became aware of the situation from a case manager. The resident told her the AP had given him a shower, but too roughly, because of the dried stool stuck to his bottom. The nurse stated the AP said other residents were complaining about the resident's odor at the dining table. The nurse stated the resident said he did not feel the AP was trying to make him uncomfortable but rather the situation made him uncomfortable. The nurse followed up with the resident afterwards and encouraged the resident to report further situations that made him feel uncomfortable.

During interview, the AP stated he helped the resident that day with his shower and during the shower, he noticed stool on the resident's body, and he washed him. The AP denied placing his finger in the resident's anus. The AP stated he told the resident the next time he had a bowel movement, to clean himself well, because it was going to smell on him. The AP stated he had always provided shower assistance with care.

During an interview, the resident stated he was able to use the bathroom by himself but needed assistance with showers. The resident stated he had problems with one caregiver [the AP] one time where the aide ran hot water up in his anus and yelled at him that he should not have stool on his body. The resident stated that aide no longer provides personal care for him.

During an interview, a family member stated the resident had not mentioned any concerns regarding the care he received from staff.

The resident's assessments completed indicated no significant changes in the resident's physical or mental health around the time and since the incident.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility suspended the AP during their internal investigation of the allegations and followed up with the resident and the AP. The facility provided the AP with education regarding therapeutic communication.

Action taken by the Minnesota Department of Health:
No action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20191	A. BUILDING: _____ B. WING _____	C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On October 22, 2024, the Minnesota Department of Health initiated an investigation of the following complaints: #HL201917648C #HL201917647C/#HL201915482M. #HL201917646C/#HL201915481M. #HL201919475C/#HL201916287M. No correction orders are issued.	0 000		